

NUTRITIONAL OBSERVATIONS IN NEW ENGLAND

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THESE nutritional observations have been made on people who are going about their usual duties. It is in no sense, a clinical study. These nutritional status surveys have consisted of a physical examination, a blood examination and a nutritional record of a group of subjects. They have been conducted by the New England Nutritional Field Unit of the Public Health Service consisting of a physician, a chemist and his technician, and a nutritionist, who are helped in carrying on their specific activities by a public health nurse and a stenographer.

The three items which have been investigated are:

- (1) the physical signs of deficiency disease;
- (2) the blood levels of certain nutrients; and
- (3) the record of food intake.

The physical examination conducted by the physician has not been of the standard type ordinarily used in the hospital. It has been limited to those signs which appear frequently when nutrition has been deficient over some period of time. The items looked for are primarily surface conditions easily seen but often not recorded in the customary type of examination. For instance, aside from general appearance, we are looking in these examinations for (1) possible signs of Vitamin A deficiency, such as Xerosis or folliculosis of the skin, or conjunctival folliculosis, or blepharitis; (2) signs of riboflavin deficiency, fissures or scarring at the corners of the mouth or at the outer canthus of the eye, or circumcorneal injection; (3) signs of niacin or B complex deficiency as possibly shown by glossitis, with atrophy of the filiform or fungiform papillae or fissuring of the tongue; and (4) possible signs of ascorbic acid deficiency as shown

by inflammation, recession or retraction of the gums.¹

The condition of the teeth has been noted. Skeletal changes are noted for signs which might mean present or past rickets, and the reflexes such as the knee jerk and ankle jerk are recorded. It has been felt by such physicians as Kruse,² Jolliffe,³ Youmans⁴ and others, that there are relationships between the presence of some of these conditions and deficiency in one or more of the vitamins or other nutrients.

I would like to quote Dr. Jolliffe:

"In connection with the signs of malnutrition it is necessary to emphasize four important points. The first is that with but few exceptions the signs are non-specific and may be produced by trauma other than malnutrition. No single sign of malnutrition is necessarily diagnostic. Other possible causes must be ruled out. The second point is that signs of malnutrition may occur in persons consuming diets ordinarily considered adequate. Conditioning factors frequently interfere with the digestion, absorption or utilization of essential nutrients. They may also increase the individual requirements for these nutrients. The third point is that the acute and chronic lesions of malnutrition differ considerably in onset, development and response to therapy. Acute lesions are rapid. Chronic lesions are slow. Furthermore, acute lesions may be superimposed upon chronic lesions. The fourth point is that with few exceptions, lesions of malnutrition due to deficiencies are multiple."

We have had great hopes that micro-chemical methods would help us in our examination of blood levels of nutrients. We have not yet obtained a sufficiently large repertoire of tests to give a complete picture of nutrients in the blood. In these nutritional status surveys hemoglobins were always taken. Vitamin A and ascorbic acid determinations were made on many subjects by micro methods from a fingertip drop of blood. We do not yet have chemical tests that are satisfactory for mass observations in the B-complex group.

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* Presented before a Joint Meeting of the Providence Medical Association and the Providence District Dental Society, at Providence, R. I., February 5, 1951.

Food intake records have been used for a number of years. These records are obtained by questioning the patient. They are not as ideal as having actual records of weighed portions of food. There is considerable discussion as to the preferred type of nutritional history. We believe that a twenty-four hour record is often as informative as a one-week record, because most people have a rather fixed pattern of food consumption. In most of our studies we have used the one-day diary record.

⁶The nutritionist compares the food intake of the subjects with the standards of the National Research Council.

The recommended allowances of the National Research Council have come in for considerable criticism, because they are held to be too high.

In Table I are four examples from the recommended daily allowances given by the National Research Council.

In defense of them, Dr. Russell Wilder⁵ of Rochester, Minnesota, says that they are so set to provide for those normal persons who need more than the average person. This amounts to a 30% factor of safety, but their goals are attainable according to Dr. Wilder and can readily be reached with low-cost dietaries with foods which contain the nutrients which they ought to have, and have not lost nutrient values through refinement, poor cooking, or through the substitution of vitamin-poor foods such as sugar.

There is a wide range between the optimum intake and the intake which carries an adult or child along successfully so far as can ordinarily be seen.

There is another wide gap between this intermediate level or level of mediocre nutrition and the level where there is starvation for one or more

of the nutrients. There is also tremendous variation in the time required for living on an inadequate diet before changes in blood or visible tissues take place. Altogether it makes the determination of nutritional deficiency difficult.

The Nutrition Unit made observations on eight groups:

The school children in a Vermont city
Families in a Vermont rural village
School children in a well-to-do Boston suburb
School children in a Vermont private school
Inmates of a New Hampshire school for feeble-minded
School children in a Maine Indian reservation
Children in a New Hampshire orphanage
Patients of the New Haven Hospital Dispensary
Obstetric Clinic

A number of other studies have been carried on by medical schools, and the Home Economics Departments of our state universities. Because of the interest of the University of Vermont Medical School, more children have been examined in Vermont than in the other New England states, but Dr. Mary Clayton of the University of Maine has made comprehensive studies in several Maine towns, around Bangor. Dr. Martha Potgieter of the University of Connecticut has an active program concerning eating habits going on in Windham County, Connecticut and studies are going on on small groups where there is a chance for more chemical determinations at the University of Massachusetts and by the Rhode Island Health Department and the Rhode Island Experiment Station.

The young people at the private school in Vermont were apparently the best fed. Their physical examinations were done by Dr. John Browe of

TABLE I
RECOMMENDED DAILY DIETARY ALLOWANCES

Revised 1948

Food and Nutrition Board, National Research Council

	Calories	Protein grams	Calcium grams	Iron mg.	Vitamin A I. U.	Thiamine mg.	Ribo- flavin mg.	Niacin mg.	Ascorbic Acid mg.	Vitamin D I. U.
Man (154 lb., 70 kg.)										
Sedentary	2400	70	1.0	12	5000	1.2	1.8	12	75	(1)
With Heavy Work	4500	70	1.0	12	5000	1.8	1.8	18	75	(1)
Woman (123 lb., 56 kg.)										
Lactation	3000	100	2.0	15	8000	1.5	3.0	15	150	400
Boy 16-20 yrs. (141 lb., 64 kg.)	3800	100	1.4	15	6000	1.7	2.5	17	100	400

- (1) The need for supplemental Vitamin D by vigorous adults leading a normal life seems to be minimum. For persons working at night and for nuns and others whose habits shield them from the sunlight, as well as for elderly persons, the ingestion of small amounts of Vitamin D is desirable.

Burlington, Vermont, now Chief of the Bureau of Nutrition of the New York State Health Department.

In this private school he found too little in the way of physical signs possibly related to nutrition, to give any record. The chemical examinations in this group were done by urine load tests, with no signs of deficiency.

The diet histories were better than most, although not perfect. Adolescent girls trying to spoil good figures by unsatisfactory thinning regimes were found here just as in many other communities.

The next most favorable picture of nutrition was that of the schools in the Boston suburb. 9% showed one or another signs suggesting possible nutritional deficiency.

Signs of Vitamin A deficiency, such as blepharitis, folliculosis of the conjunctiva, folliculosis of the skin or Xerosis were present in from 1 to 5%. Possible signs of riboflavin deficiency, cheilosis, angular stomatitis or fissures at the outer canthi of the eyes appeared in 6%. Gum inflammation, recession or retraction appeared in from 2 to 7%. Tongue changes, such as fissuring, gave 3%. Signs of former rickets were noted in 5% and only 2% showed any loss of reflexes or abnormalities of vibratory sense.

Only 3 of these 400 children were underweight but 31 or 8% were 20 pounds or more overweight. Average hemoglobin levels were satisfactory, being between 13 and 14 grams, but 71 of more than 400 had levels below 12 grams and 10 fell below 11.

The Vitamin C (ascorbic acid) blood levels in this group were also well up on the scale since the mean level for all was 0.90 mg. %. 70% were above 0.60 mg. % so that there must have been a considerable number with values above 1.00 mg. %, but even with this good result, 30% of boys and 31% of girls had ascorbic blood levels below 0.60 mg. %, or below the good category.

Apparently the inadequacies of nutrition are not all due to the economic disadvantages. In a group of this sort these inadequacies come from unintelligent use of food, the avoidance of good foods, the substitution of low value foods through false information or poor reasoning. This is said because the largest number who deviated from reasonable nutritional health were once again the high school girls.

The next group were children from the 3rd grade through high school in a children's home in New Hampshire—again a group living and working on a farm with a superintendent greatly interested in nutrition—both of the children and of the farm animals. As he pointed out from his experience: When he fed his pigs what humans ate in wastes or refined grain products his sows got along

but they didn't hit an outstanding pace for growth or productivity. When he fed growing mash, he was sold some of the bran and germ separated from the flour being sold for human food, and the pigs made better growth. When he fed breeding mash—made from the rest of the grain which we humans are not so likely to get—he really got opulent health and vigor and his sows were prolific, to say the least. It was amazing, according to Mr. Sherman, to see how a few days of feeding breeding mash changed the activity of the animals in the piggery.

The children were not all free from gum disturbances, or eye changes or roughness of the skin. The incidence was a little greater than among the children in Vermont and Massachusetts who had had the advantage of well-to-do home life.

Among the orphanage children the ascorbic acid levels were the highest of any group. The girls averaged 1.15 and the boys about 0.98 mg. %. There were some gums which would bleed easily however, and we would have to admit that 15% of the group had mild changes in the gums which could be called gingivitis.

The hemoglobin levels were at 13.2 grams for the girls and in the usual expectation by age levels for the boys, from 13.0 grams for the younger ones to 13.7 g. for the boys over 14.

The selection of food was very good. Green and yellow vegetables, and citrus and other ascorbic acid carrying fruits and vegetables were had in far better than average quantity. Milk was in abundance, meat was adequate, bread was enriched.

As I have said, the signs of deficiency were more numerous than in the two better groups, the Vermont Private School and the Boston suburb, but many of the children had been with the Home for only a few months, and orphans or youngsters from broken homes are not likely to have had the best of nutrition during the days with their parents or relatives. I had hoped it might be possible to make observations in later years on this school because I would expect to find improvement—visible physical improvement—in many of the children who had been chronically undernourished when they entered.

The next three groups have not had as good opportunities for optimum nutrition as the first three. They are rural groups or at least close to rural sources of food—as found in northern New England. The school children of the Vermont city—1800 of them—showed numerous physical signs of deficiency. In most items they were about the same as in the Boston suburbs, but 8% were underweight and from 10%-30% showed signs of Vitamin A deficiency. Only 6% showed gingival disturbance. The intake records obtained by the nutritionist were low in the Vitamin A foods—

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only about one-half having amounts approaching the recommended allowances of the National Research Council. They were also much lower in protein, meat, cheese and eggs than in the Boston suburb.

Of particular significance was the contrast between a large school group from the less favored part of the town and the schools where economic and social conditions were better. The hemoglobin level was lower and the incidence of physical signs nearly double among the less favored group.

The group giving an even higher incidence of physical signs among children was found way down east on the shores of the St. Croix river. Here were a hundred children attending the school on the Indian Reservation.

Folliculosis of the skin, of the conjunctivae, etc., were high—nearly one-half of the youngsters showing at least one of these signs, and one-third of them showed gingivitis. This group really was getting poor living in foods rich in Vitamin C. Our nutritionist could only find 10% getting near the recommended allowance of these materials, and their Vitamin A intake was likewise extremely low. Milk and meat were also low—only 22% were getting the recommended allowance of milk—a low figure for school children in New England, and only one-half of the recommended allowance for meat was being eaten. Our families—rich or poor—usually get a pretty good supply of meat regardless of other foods. Cheese and eggs were very low also but enriched bread was had by everyone and butter was more frequently served than in even the rich Boston suburb. Butter was a commodity which could be supplied by the State to its wards.

The C blood levels were fair to low in this group, the average for the boys being .4 and for the girls .6. We did not find any scurvy, even though individual readings were close to zero.

The local physician was greatly interested and tried two approaches—for one classroom 4 oz. of tomato juice was served each school day at recess for four months. The blood Vitamin C level of the group rose by .25 milligrams per cent, bringing a low "fair" level to a good level. One large family was found with gingivitis in every member. This group was given 200 mg. of Vitamin C daily by tablet for a period of three months. In his opinion, there was improvement of the gums.

The effective approach for the State of Maine, faced with the care of these Indian children, was to provide a high grade hot lunch at the school. It made a difference in the general appearance and in the interest, enthusiasm and mischievousness of these Indian children but there were too many factors to permit a significant statistical determination of an improvement.

Two adult groups remain for us to consider. In one of these groups there were some children, but the difference from the groups so far discussed, will come because of the greater ages. The first of these was in a village in Vermont where some 350 people of all ages were examined. The second was a small group of 60 women from the obstetric clinic of Dr. Herbert Thoms at the New Haven Hospital Dispensary. From the standpoint of physical signs we find higher percentages as we study older groups. As I mentioned earlier, Dr. Jolliffe has pointed out that irritants and trauma can be fully as responsible for these skin and surface changes as can nutritional factors. In the Vermont village we find that about 20% showed signs of Vitamin A deficiency and 12% had gum disturbances suggesting C deficiency. In this older group we had very few persons underweight but about 20% in the overweight category. Fissuring and atrophy of the tongue, factors which we have not noted before in any great quantity, appear in these ages. In the Vermont village 31% showed these changes. The New Haven mothers also showed considerable tongue changes, but not as great an incidence of folliculosis of the skin or conjunctivae. Other possible signs of Vitamin A deficiency were rare. Overweight was not as frequent as among the women in the country village. There were no signs of thiamine deficiency in the New Haven mothers, but the gum changes were more numerous than in any other group. They were as frequent (50%) as in a school for feeble-minded where the blood level average of ascorbic acid was only 0.25 mg. % in two dormitories, distinctly in the low category. It may be interesting that the blood levels of the women in New Haven averaged only 0.40 mg. %, also distinctly low. The loss of teeth was more serious than among the Vermont villagers. Hemoglobin levels were low, the average being 11 grams.

Of course these examples are much too small to give a complete picture of the status of 7 or 8 million New Englanders. The most important point is that the group that is having the most trouble is the young mothers, who are giving themselves a poor choice of food because of the economic problem of feeding their families. I feel that the New Haven group is only an illustration of a common condition throughout the country.

Next after the adult women in showing the most signs and in having the poorest blood levels are the next generation of mothers, the high school girls, whether they are in the well-to-do private school, the rich suburb or in the rural schools. Education and understanding is of great importance. The mothers may be giving themselves the poorest diets because of economic reasons but more likely because they really do not understand the possibilities of foods. Certainly the high school girls are

doing without certain foods, not so much from the economic standpoint but because they have not learned their glamour lesson quite well enough. This does not mean that the men are so superior to the women and probably if the women were not looking after the men, the men and boys might be worse.

Our nutritional problems are these. There seems to be inadequate intake of foods rich in ascorbic acid and in Vitamin A or carotene, and in some areas of Vitamin D. There is neglect of food sources of the less expensive proteins, peas, beans, nuts, and milk. Too great consumption of high calorie, highly refined foods lacking in other nutrients produces obesity. It may seem paradoxical, that obesity should be a major nutritional problem, but it is a health problem for about one-third of Americans.

From the standpoint of ways and means for accomplishing something in improved nutrition for the masses of our people we have to work along three lines. First comes the matter of economics and as people have better incomes and living conditions they will improve their nutrition. Secondly, education is of equal or greater importance. The well-to-do Boston suburb had economic advantages but it also had educational advantages in the form of a school and health department program of nutrition furnished by an excellent nutritionist. It was education and understanding that gave us the better levels of health in the New Hampshire orphanage and in the Vermont private school.

The third point is the provision of foods that will reach everyone and contain larger amounts of essential nutrients than people are now getting. This can apply to the nation as a whole although perhaps it is shown best in the care of people in institutions. One cannot do much with feeble-minded students from the standpoint of education. The same holds for many other inmates of institutions. Economics is a matter for the superintendents of the institutions. Results are obtained when we learn those foods that are most nearly universal in use and then make them just as complete as possible. For instance, New York State, through its Mental Hygiene Division, has developed an enriched bread to which has been added more than the usual amount of protein by means of soy flour. Bread is a universal substance in the diets of institution inhabitants. It would not have been necessary to have made this bread more palatable for it is something that people wanted for a second helping anyway, but when it was enriched it was tastier and more satisfying. This has been introduced in New York institutions and is being adopted in institutions in other states, as in Vermont. The use of this bread was one of our major recommen-

dations to the State school in New Hampshire. Actually it costs less than a cent a pound more than the breads of much less value which were being used. Not only is this type of bread being adopted by institutions but it is rapidly being developed and promoted by private bakeries in New York and in Connecticut. This type of distribution of high nutrient food is of more far reaching importance than education or improved economy. Bread is not the only food. We noted that in several of these groups with the less adequate diets, milk was badly neglected. In dealing with bread and milk we have the economic side with us. There is more difficulty in getting wider use of more fruits and vegetables and meat because of their expense. Education will have to take part here. Unfortunately, we are up against tremendous advertising campaigns to utilize particular foods.

When your health officer begins his program for better nutrition he will very likely find that small examples of nutrition education will be one of his best means of working toward opulent health.

An interesting rural pattern for the improvement of eating habits began a little over a year ago in Chester, Vermont. Two physicians take care of Chester. They had no one but themselves to promote better health in their area. There was no health department. They offered urine sugar tests to the entire area in a case-finding program for diabetes. Their laboratory did the work. They made the diagnoses. This was a smart procedure, it prevented duplication, it reduced cost, it channeled responsibility into a short channel.

But they needed help. They called on the Public Health Nurse and the Public Health nutritionist. These girls planned the nutrition education to keep family life cheerful and economical for the diabetic. Diabetic clubs were formed in Chester and Springfield. At the last meeting of the Chester Club 38 members were present and they were ready to go beyond their own health problems to help their physicians obtain their next wish for the town, a school nurse. Education in better eating will spread from the diabetic families to families with infants and then to other families with wide-open ears and plenty of food problems.

Why has such an interest in nutrition taken hold in this little town in Vermont? Partly because two good teachers went in to answer questions, but primarily because the two physicians of the town told their patients of its importance. Nutritionists can provide excellent and valuable information but the faith of the people in their physicians and dentists is profound when it comes to the matter of what they ought to eat. You doctors are the real health educators.

REFERENCES

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TETANUS AT THE RHODE ISLAND HOSPITAL, 1930-1950

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TETANUS is a rare disease at the Rhode Island Hospital. There have been only fifteen cases of tetanus from 1930 until 1950. During the years from 1930 until 1950, there have been 217,166 admissions to the hospital. The fifteen cases of tetanus are spread evenly throughout this twenty-year period.

With such a small number of cases to analyze, only the most general conclusions can be drawn. However, certain interesting facts are presented in review of the 15 cases of tetanus.

Age: The average age was 24. Six of the cases were over twenty years of age and nine other cases were under twenty. The youngest was five years of age; the oldest was 64 years of age.

Sex: Eight of the cases were male; seven were female. Ten of the cases were Italian.

Source of infection: In three of the fifteen cases, the site of infection was not known. Of the remaining twelve cases, one case was thought to be due to a broken, unsterile hypodermic needle and that was injected by a chronic drug addict. One case was a chronic leg ulcer that had been treated by searing with a red hot iron. A third case was an extensive third degree burn for which the patient had been hospitalized at the time of the onset of tetanus. Of the other nine cases, injuries were in the form of minor cuts, splinters, small fractures. Six of the nine trivial injuries occurred in the hand and the other three occurred in the foot. There were no massive compound fractures or dirty wounds amongst the cases. Of the fifteen cases, four of them were seen by M.D.s at the time of the original injury. Two of these were seen in the Accident Room of this hospital and one was seen by a local M.D., while the fourth was hospitalized at the time of the onset of tetanus.

Incubation period: The incubation period was known in ten cases, varying from six to nineteen days with an average of nine days. Of the five fatal cases, the incubation period was known in three, varying from seven to ten days. Ordinarily,

the shorter the incubation period, the graver the prognosis. Three cases with short incubation periods, six, seven and eight days respectively, all lived. These patients were ten, fourteen and 31 years of age.

Onset of symptoms: The time interval from the onset of symptoms until hospitalization varied from one day until six days. One 64-year-old patient had symptoms for six days prior to admission and died hours after admission to the hospital. However, three of four young patients who had symptoms of tetanus, including convulsions for three to four days before admission, survived. All other patients had symptoms from one to two days before admission to the hospital.

Symptoms: All of the patients had trismus or "lockjaw" at the time of admission to the hospital. Other than trismus, the most frequent symptoms were abdominal pain, back pain, generalized stiffness, convulsions and dysphagia. Certainly any patient with trismus or "lockjaw" should be treated as tetanus until proven otherwise.

Prophylaxis: None of the fifteen cases had received active or passive immunization prior to the onset of symptoms.

Hall⁹ shows that during World War II, the Army and the Navy proved beyond any doubt the value of active immunization. All Army and Navy personnel were actively immunized. In the Navy, no combat casualties developed tetanus. In the Army, there were only twelve cases of tetanus and five deaths from tetanus. Only two of the five had been properly immunized. In the cases that have received active immunization and then developed tetanus, the incubation period is usually longer, the disease runs a milder course and the prognosis is far better. In the German Army, however, Graham¹² reports that the great mass of the German Army received no active immunization and tetanus was frequently encountered in German prisoner casualties treated in the United States military hospitals.

Length of hospital stay: Of the survivors, the hospital stay ranged from fifteen to thirty-one days, except for the last case in 1950 which was hospitalized for fifty-three days because of many

complications. Of the five fatal cases, the hospitalization ranged from one to three days. Four of the five fatal cases were in the hospital for only fifteen to thirty-six hours prior to death. The fifth case lived three days.

Fatal cases: Five of the fifteen cases died. One child remained in the hospital for one day, during which time the patient received tetanus antitoxin intravenously and intrathecally. That evening the temperature rose from 100 to 106 and the child was taken from the hospital against advice, the fate of the child being unknown. Thus, the mortality for tetanus would be 35%. Vinnard⁶ reports 352 patients with tetanus treated in the Charity Hospital of Louisiana at New Orleans during the ten-year period from 1934 to 1944, with a total mortality of 45%.

Treatment: Six of the cases were treated on the Surgical Service; four cases on the Pediatric Service; four on the Neurological Service and one on the Medical Service.

Tetanus antitoxin therapy: In considering the treatment of tetanus, the patients with tetanus can be divided into three groups; those with a fixed lethal dose of toxin for whom no form of treatment will be of avail; secondly, there are those with a non-fatal dose of tetanus who would probably survive without treatment; then there is the intermediate group that we hope to save with proper treatment. In order to determine, or help to determine, which group the patient falls in, Pratt's¹⁰ four criteria are helpful. Consider first of all the length of the incubation period, usually a longer incubation period being more favorable; secondly, the length of time from the onset of symptoms to the onset of episodes of general muscle spasm, the longer the length of time the more favorable the prognosis; third, the physical findings on examination of the patient at the time of admission; fourth, the frequency and severity of convulsions after sedation and the amount of sedation required.

Thus, if we consider each case from the standpoint of severity, we are far less prone to over treat the patient.

Dietrich² analyzed his thirteen fatal cases, considering the length of time they lived following the first administration of tetanus antitoxin. He found that eleven of the cases died within fourteen hours after the first administration of serum. He felt that the picture of tetanus with a clear mentality, frequent tonic spasms, slightly elevated temperature and pulse rate was suddenly changed following the administration of serum to resemble certain phases of bulbar poliomyelitis or some other disease with medullary pressure or edema. The new clinical picture was one of coma, hyperpyrexia, tachycardia and cessation of tonic convulsions.

Therefore, he felt that moderate doses of serum are adequate in the treatment of tetanus and that intrathecal administration of serum was unsound and practically dangerous, especially in treating children. The intravenous administration may cause fatal reactions, but a single dose on admission is theoretically advantageous. Intramuscular administration of the antitoxin is the safest and is probably adequate except in the most severe cases.

In reviewing the five cases in our series that died, it is noted that four of them died within 36 hours after the first administration of tetanus antitoxin. All routes of administration were used in the 15 cases, intramuscularly, intravenously, intrathecally, injection into the site of the infection and cisternal puncture. Of the five patients that died, one was the youngest, being five years of age, three of them were the oldest being 54, 61 and 64 years of age, while the fifth was a 39-year-old chronic drug addict and in extremely poor physical condition. These five patients then would be least likely to withstand a severe reaction to the serum.

The first case was that of a 39-year-old drug addict, in poor condition, who entered with a temperature of 101 and died 30 hours after the first dose of tetanus antitoxin. The temperature promptly rose to 105 degrees following intrathecal administration of 15,000 units of tetanus antitoxin and remained at that level until death. The patient got a total of 93,000 units of tetanus antitoxin intravenously and intramuscularly in the thirty hours from the first dose until death.

The second case was that of a 64-year-old female who received 65,000 units of tetanus antitoxin in the 15 hours from the first dose until her death. Ten thousand units were given intrathecally. On admission her temperature was 100 and following the tetanus antitoxin, her temperature rose to 104 and remained there until her death fifteen hours later.

The third case was that of a 61-year-old white female who was given 98,000 units of tetanus antitoxin intravenously and intramuscularly following admission. Patient died twenty hours after admission.

The fourth case was that of a 54-year-old male. On admission his temperature was 99. He was given 60,000 units intravenously and 40,000 units intramuscularly and on the second day, his temperature rose to 105.5 where it remained until his death three days after admission. He received a total of 300,000 units intravenously and intramuscularly in the first two days. This patient was on penicillin for his entire hospital period.

The fifth case was that of a five-year-old child who was hospitalized for severe third degree burns. She was on penicillin every three hours at the time of the onset of trismus on the tenth hospital day.

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Her temperature had been 102 to 103 daily. Following the onset of trismus that morning, the patient was given 20,000 units intramuscularly and that afternoon was given 5,000 units by cisternal puncture. That evening her temperature had risen from 103 to 107 and remained at that level until death 36 hours following the first dose of tetanus antitoxin. She was given a total of 85,000 units intravenously and intrathecally in 36 hours.

The seven-year-old child who was taken out of the hospital against advice, showed a startling hyperpyrexia. On admission the temperature was 100 degrees. At that time, 10,000 units of antitoxin was given intrathecally, 10,000 was given intramuscularly. The temperature rose from 100 to 106 and at the end of twelve hours, the patient was taken out of the hospital.

Of the nine surviving cases, the total dose of tetanus antitoxin varied from 120,000 units to 560,000 units. The survivor with the greater number of units of antitoxin, also had the highest and most prolonged temperature. This patient was a 27-year-old white female in excellent physical condition who had a temperature of 106 to 107 rectally for a period of five days, during her treatment with tetanus antitoxin. Judging by Pratt's criteria, this patient had a mild case of tetanus. Her incubation period was the longest, being 19 days. She had mild tetanic spasms but no convulsions. On the day of admission, she was given 40,000 units of tetanus antitoxin intramuscularly and at that time her temperature was 99. Her temperature rose to 101 on the second day. On the second day she was given no tetanus antitoxin and on the third day, she was given 120,000 units of tetanus antitoxin. That evening, her temperature was up to 104. On the fourth day she got 100,000 units intravenously. Her temperature then rose to 106. On the fifth day, she got 200,000 units intramuscularly and 100,000 units intravenously. Her temperature rose to 107 and remained between 106 and 107 for four days. She received no more tetanus antitoxin and the temperature slowly went down to normal. This startling and prolonged hyperpyrexia was without any doubt a manifestation of reaction to the serum therapy, that might have proven fatal in a person without the advantage of youth and excellent physical condition.

The last case of tetanus at this hospital was a 14-year-old girl who received 480,000 units of tetanus antitoxin in 40 hours. Her temperature on admission was 99. She did not appear acutely ill and had only mild tetanic spasms. Her temperature rose from 99 to 106 on the third day following 400,000 units of tetanus antitoxin in 40 hours. This temperature remained between 106 and 107 for three days following the administration of

serum and then gradually fell to normal level and the patient survived.

In treating tetanus, it is well to consider the severity of the case and to give a moderate amount of antitoxin within 24 hours after admission, half intravenously and half intramuscularly, and not to over treat the patient with massive doses intravenously and intraethically and thus produce a fatal reaction to the serum. A total dosage of 100,000 units given within the first 24 hours, should be sufficient to fix circulating toxins. One-half should be given intravenously and the other half intramuscularly. Circulating antitoxins will persist in therapeutic levels to neutralize any more toxins that might be liberated from the site of infection. There is no proven value for intrathecal administration, yet it can provoke a fatal reaction to the serum.

Seven of the nine survivors in this series developed urticaria five to eleven days following the administration of tetanus antitoxin. In all cases, the skin lesions disappeared in a few days.

Antibiotics: There is no evidence that any of the antibiotics alter the course of the disease. They are given mainly to prevent the pulmonary and other complications of the disease. Five of the fifteen cases were treated with penicillin, 15,000 to 100,000 units every three hours with no noticeable effect on the course of the disease. One case was on penicillin at the time of onset of symptoms. One other patient received 400,000 units of penicillin prophylactically at the time of the original injury. The last case had some small doses of aureomycin and streptomycin but not enough to warrant consideration.

Graham¹² reported that nine of his ten cases had received considerable amounts of both penicillin and sulfadiazine for wound infection prior to development of tetanus.

Sedation: There is a voluminous literature on the efficacy of various sedatives in the treatment of tetanus. It is wise, however, to choose two or three reliable sedatives that are relatively safe and effective for prolonged sedation over a two to three week period. These two or three drugs can be used in rotation to prevent developing a tolerance to one. The aim in sedation of course is to prevent exhaustion of the patient and also to prevent vertebral fractures, and yet not enough sedation to produce pulmonary complications. When a prophylactic tracheotomy has been performed the pulmonary complications are far less.

Tracheotomy: The last case had a tracheotomy performed on the second day and was maintained until the 14th day. The tracheotomy has been proven to be an invaluable aid in the treatment of tetanus and should be done prophylactically.

In a general hospital, the cases of tetanus are so few and far between, that it is well to enlist the aid of a doctor who has successfully treated a case of tetanus previously. In this way, one can avert the dangers of over treatment and also establish on admission a proper therapeutic regimen rather than arriving at one by trial and error in the treatment of a first case. The establishment of a therapeutic regimen as to nursing care, time of treatment, amount of sedation, etc., is extremely important. Graham¹² states that an important factor in the successful treatment of six of his ten cases of tetanus was the increased experience in handling the problem gained during treatment of the first three fatal cases.

Complications: Roberg¹ described cases to show that kyphosis of the vertebral column may follow tetanus with or without demonstrable fractures of the vertebral bodies.

Dietrich² demonstrated compression deformities of one or several dorsal vertebrae in nine of thirteen survivors of tetanus. This was 65% of the survivors. The most common vertebrae affected are D-5 and D-6. This differs from juvenile dorsal kyphosis where the lower lumbar vertebrae are most often involved, usually D-8 and D-9. In traumatic compression fractures, usually D-12 and L-1 are the most commonly involved. The fractures seen in tetanus are similar to those observed following metrazol induced convulsions for the treatment of psychiatric disorders.⁴ In the last seven cases of tetanus treated at this hospital, three of the patients died. Only one autopsy was obtained and at that autopsy, the vertebral column was not examined. Of the four surviving patients, x-rays revealed no compression fracture nor kyphosis.

Harris⁷ reports only one patient with compression fracture of the dorsal vertebra out of twelve patients in the past ten years. This incidence of compression fracture is far less than the 65% reported by Dietrich² in 1940. This markedly lowered incidence may be due to more adequate use of sedatives with smoother sedation.

Sequelae: Five of the nine survivors exhibited slight generalized stiffness at the time they left the hospital. Their average hospital stay was from 15 to 31 days. Two of the five had stiffness at the site of infection. However, four of the survivors have been followed at this hospital and at the last examination this year, these four patients exhibited no symptoms whatsoever attributable to tetanus and were in excellent health.

Summary

Tetanus is a rare disease at the Rhode Island Hospital. There have been only 15 cases in the past 20 years and these cases were reviewed.

The three patients with the shortest incubation periods all survived.

All 15 cases had trismus or "lockjaw" on admission.

In treating tetanus, a fixed dosage should be used and no more given than necessary with a maximum of 100 to 200,000 units total dosage. A fatal reaction to tetanus antitoxin may be precipitated by over treatment.

The value of early prophylactic tracheotomy has been proven. Prophylactic tracheotomy should be performed early in the disease.

For sedation, two or three dependable drugs should be used in rotation over the two to three week period in which they are necessary.

All survivors should be routinely x-rayed to reveal possible compression fractures of the dorsal vertebrae.

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NUTRITIONAL OBSERVATIONS IN NEW ENGLAND

Concluded from page 253

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SARCOMATOUS TRANSFORMATION OF PAGET'S DISEASE OF THE SKULL

— A Case Report —

LT. (jg) EDWIN M. KNIGHTS, JR., MC, USNR

The Author. Lt. (jg) Edwin M. Knights, Jr., MC, USNR, of Providence. Former Junior Resident Pathologist, R. I. Hospital, and Assistant Resident Pathologist, St. Luke's Hospital, New York City.

LITTLE doubt now remains that sarcomatous degeneration is a frequent complication of Paget's disease of the bone, or osteitis deformans. While the incidence varies in the reports in the literature, most authors have reported malignant degeneration in five to fourteen per cent.¹

Unlike uncomplicated osteogenic sarcomas, those secondary to Paget's have the peculiar characteristic of often affecting multiple bones in the same individual.^{1,2} These bones are usually those already involved by Paget's disease. The lesions must be differentiated clinically from other types of tumors arising in bone, metastatic carcinomas, and infectious processes.³

The case which follows illustrates the sudden and dramatic demise which may terminate a case of Paget's disease. A strikingly similar case was reported by Kirshbaum in 1943,⁴ and other cases were described by Packard and Steele,⁵ Bird,³ and Summey and Pressly.¹

Case Report

The patient was a seventy year old white female admitted to the Rhode Island Hospital for a slowly-growing tumor mass in the right fronto-parietal area of the skull. The duration of this mass was not known, but the patient stated it had grown progressively during recent months and had remained painless. Aside from occasional earaches on the right side, the patient had no other complaints. She had been admitted seven months previously for a compression fracture of D-12, and following discharge from the hospital the patient frequently crawled about on her hands and knees, because of her fear of falling.

Admission physical examination revealed a blood pressure of 160/110, temperature 100.2, pulse 72, respirations 16/min. The patient appeared in no acute distress, but answered questions slowly and exhibited difficulty in recalling details. A "fairly firm" mass was described in the right fronto-parietal area 5 x 10 cm. in size and immovable.

The base seemed to consist of bony substance, almost fluctuant at the lateral aspect. The calvarium appeared to be symmetrically enlarged.

While in the hospital, the patient suddenly developed weakness of the left side of the mouth and shortly thereafter she vomited and complained of discomfort in her head. She became progressively worse, developed left hemiplegia, became incontinent and finally lost consciousness. She expired on her third hospital day.

Laboratory Results

Blood: Hemoglobin 12.9, white blood count 17,250 with 92% neutrophils, 6% lymphocytes, 2% monocytes.

BUN 26, glucose 144, calcium 10.2, inorganic phosphorus 3.5, and alkaline phosphatase 80 K-A units.

Clinical Diagnosis

Paget's disease of skull
Sarcoma of skull
Hypertensive cardiovascular disease
Generalized arteriosclerosis
Right cerebrovascular accident

* * *

At autopsy, the patient was a poorly nourished white female who had a moderately firm mass in the right fronto-parietal region of her skull. This mass appeared to arise from the calvarium. It measured 7.5 x 6.0 cm. and extended 3.0 cm. above the calvarium where it was adherent to the overlying scalp but did not penetrate the skin. It had also grown downward, compressing the dura and the underlying right frontal lobe. Sectioning of the tumor showed that it cut with variable resistance and varied in color from reddish-blue to pinkish-gray. Small bone spicules were encountered grossly on sectioning. No extensive intracranial hemorrhage was noted on removal of the calvarium, but hemorrhagic discoloration surrounded the eroded area in the right frontal lobe for a distance of 3 cm.

The skull sawed with less than average resistance and was found to average 1 cm. in thickness, reaching 1.4 cm. in thickness in the right parietal and occipital areas. Its cut surface was orange and slightly porous, with complete obliteration of the tables.

Examination of the brain showed asymmetry of the cerebral hemispheres, with bilateral evidence of compression. There was a defect where the tumor had penetrated the right frontal lobe in the caudal limits of the inferior frontal gyrus. The pia-arachnoid about this defect contained blood which extended out in a circular manner for a distance of about 5 cm. in diameter. Cross-sections showed hemorrhage in the centrum ovale underlying the defect, and a break-through into the right lateral ventricle. The head of the caudate nucleus was destroyed. Numerous other small hemorrhages were also found in the brain stem, in the colliculi, and in and about the red nucleus on the left side.

Evidence of Paget's disease was not encountered in any other bones of the body. The twelfth thoracic vertebra, which was said to have been previously fractured, showed no gross or microscopic abnormalities.

Other findings included grossly visible bronchopneumonia of both lower lobes, generalized arteriosclerosis, and arteriolar nephrosclerosis.

Microscopic Examination

Microscopic examination of the tumor mass in the skull presented a picture of osteitis deformans with a superimposed osteogenic sarcoma.

Numerous lamellae were seen joined by irregular pale blue cement lines into a bizarre pattern lacking any regularity. The bone was laid down in a haphazard pattern, combining with the cement lines to give the "mosaic appearance." Large vascular spaces filled with red cells and numerous polymorphonuclear cells were also present. These were seen to be lined with endothelial-type cells in most instances. A considerable amount of loose fibrous connective tissue was present among the bony spicules.

Arising from this picture was the tumor mass, which was highly vascular and filled with spindle cells and round cells showing considerable irregularity of size and shape. Many of the nuclei were hyperchromatic and mitoses were frequent. Multinucleated cells, averaging between four to ten nuclei, were encountered in considerable numbers, with as many as five or six per high-powered field. Small irregular areas of cartilage formation were also present.

Conclusions

Osteogenic sarcoma in Paget's disease, which has almost invariably proved fatal, must be considered the most important of its complications. Its frequency (5-14%) makes it a complication always to be kept in mind, as early discovery and prompt treatment appear to offer the only hope of cure. As X-ray therapy has shown to be quite ineffective against osteogenic sarcomas,² radical surgical ex-

tirpation appears to represent the treatment of choice, at least in monostotic cases.

Summary

A case is described in which sarcomatous transformation occurred in Paget's disease of the skull. It produced increased intracranial pressure and finally penetrated the brain, causing hemorrhage and rapid death of the patient.

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Acknowledgments

The author wishes to express his indebtedness to Dr. Herbert Fanger, Dr. H. W. Williams, Mr. George Mancini, and Mrs. C. W. Waterman.

WEDNESDAY — JUNE 6

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* * *

Pawtucket Golf Club

Tournament starts at noon

Dinner at 6:30 P.M.

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FISKE FUND ESSAY

ELSEWHERE in this issue is the announcement of the trustees of the Fiske Fund of the dissertation for 1951. The subject chosen by the trustees is: "The Present Status of Adreno-cortical Hormone Therapy — Its Uses and Limitations."

There is probably no older prize essay contest in medical circles in this country than the Fiske contest. The fund was started by Doctor Caleb Fiske in 1835 when he left the Society \$2,000, the income from which was to be used to pay a premium for the best treatise on a subject to be proposed by a board of trustees consisting of three officers of the Society. Over the years seventy awards have been made, the last in 1941.

The changing economic situation of this country is reflected in the situation that affected the Fiske Fund in the past decade. The income dropped drastically, thus eliminating the possibility of an annual prize of any consequence. As a result the fund, by court approval, has been reinvested, and the trustees are now able to offer a prize of \$200 for the best dissertation submitted this year.

However, a new step has been taken by the trustees that should win commendation. The stipulation has been made that the successful author must agree to read his paper before the Rhode Island Medical Society at its annual meeting to be held in Providence on May 15, 1952. Thus the Fiske Essay attains a new eminence, and the author additional honors. By this new action the trustees have created what may well be a parallel to the

outstanding Chapin Oration given annually before the Society in memory of the late Dr. Charles Value Chapin.

Under the rules set forth by the trustees the successful author will be unknown to them until his essay is determined the best submitted. Undoubtedly many dissertations will be submitted from various parts of the country once the prize contest is widely publicized, but nothing would make us happier than to have one of our own Rhode Island Medical Society members revealed as the winner of this important essay contest.

ANTIBIOTICS AND CHEMOTHERAPY

By the time you have read this, Volume I, Number 1, of the new periodical, ANTIBIOTICS AND CHEMOTHERAPY, published by the Washington Institute of Medicine, will be on the shelves of the Rhode Island Medical Library. Of the making of medical journals there is no end but the tremendous importance of antibiotics and chemotherapy make it well worth while that a journal is to be devoted to it.

The list of members of the Editorial Board is impressive. There can be few names well-known for their connection with this new development that are not on the list. And this list includes not only Americans but distinguished workers from the European countries and even as far away as Jerusalem in Israel.

Volume I starts off with a bang with articles by Waksman, Dowling, and Kendall. Dr. Dowling's article on THE PRESENT STATUS OF ANTI-BIOTIC THERAPY is decidedly practical. He gives a short discussion of the best known of these substances and discusses the different situations in which the different ones are used. Two warnings which he issues, we think, certainly need to be emphasized at the present time of perhaps overenthusiasm. "These combinations should not be used in a shotgun fashion, on the theory that if one antibiotic will accomplish something, two or three will accomplish more." "Any substance which is employed as a drug can produce harmful results under certain conditions...many instances of deleterious effects have been observed." That the scope of this Journal will not be too narrow is shown by the inclusion of an article by Kendall of the Mayo Foundation on THE DEVELOPMENT OF CORTISONE AS A THERAPEUTIC AGENT.

This Journal will not be clinical only but will also be devoted to experimental work. The first number is divided about equally as to this. We are pleased to herald the appearance of this important publication.

VIEWING AMERICAN MEDICINE

Every physician who has attended an annual session of the American Medical Association in recent years is familiar with the wide range of activities encompassed within the framework of this national convention. For a full week the pageantry of scientific exhibits, of brilliant lectures and demonstrations, of concentrated education, and of specialized meetings tops any performance staged throughout the year by any national group.

This year with the meeting in Atlantic City again the registration is certain to be one of the highest as the AMA celebrates its 100th annual meeting. Undoubtedly a large number of Rhode Island physicians will attend, and to those who may at this time be undecided on the matter we urge an early and favorable decision.

Of increasing interest to physicians who attended the AMA sessions in recent years has been the development of the meeting of the Conference of Presidents and Other Officers of State Medical Associations which is held the Sunday afternoon prior to the official opening of the AMA conferences. Rhode Island has a particular interest in this Conference, for under the secretaryship of our executive secretary their meetings the past two years have been outstanding in the presentation of medical-economic and sociological problems affecting medicine.

Now comes word that on June 10, at the Traymore hotel, at Atlantic City, the Conference of

Presidents will offer another array of national speakers whose views on medicine warrant far more than a passing interest. The program calls for discussions on medicine as it is viewed by a physician, an editor, a clergyman, and a legislator.

Medicine as a physician views it will be presented by Dr. W. Andrew Bunten, past president of the Wyoming State Medical Society, while the viewpoint of an editor will be given by Edwin F. Abels, past president of the National Editorial Association, and presently editor of the Lawrence, Kansas, *Outlook*.

An outstanding churchman from our neighboring state of Massachusetts, the Most Reverend John J. Wright, D.D., bishop of the diocese of Worcester, will speak to the topic "A Clergyman Views Medicine," and the legislator's presentation will be made by U. S. Senator Richard M. Nixon, the former Representative who won the senatorial race in California last fall.

At its past meeting the Conference of Presidents has listened to talks by leaders of government, labor and industry, as well as the professions. This year's program adds further lustre to the work of the Conference, and a distinct service is rendered to medicine by these prominent leaders who have consented to take time from their busy lives to bring their views to the profession at this time when sound and constructive thinking on the health problems of the nation is to be sought.

The Conference does not restrict attendance at this Sunday meeting to its membership of present and past officers. Therefore any physicians from Rhode Island planning to go to Atlantic City should arrange their arrival by June 10.

MASSACHUSETTS PREMARITAL LAW

The recently amended premarital-examination law in Massachusetts now permits city and town clerks of the State to accept certificates from 34 states, New York City, 2 territories and 1 Canadian province, provided these certificates are signed by a physician licensed to practice in the areas mentioned, and provided, also, that the blood test for syphilis is performed in the laboratory of a state, New York City or territorial health department of the United States or provincial health department of Canada.

In turn, 16 states, including Rhode Island, have agreed to accept the Massachusetts certificate signed by a Massachusetts physician, provided the blood specimen is examined at the State Wasserman Laboratory. There is no waiting period in days in Rhode Island between the application for and the issuance of the license for residents and male nonresidents, but five days are required for nonresident females. The blood test is valid in this state for 40 days.

Fiske Fund Prize Dissertation

1951

The Trustees of the Fiske Fund announce the following subject for the Prize Dissertation of 1951:

"The Present Status of Adreno-cortical Hormone Therapy—Its Uses and Limitations."

For the best dissertation on this subject worthy of a premium they offer the sum of two hundred dollars (\$200.00). The dissertation will be particularly graded on the basis of original work by the author and his observation of patients. Each competitor for the premium is expected to conform with the following regulations:

To forward to the secretary of the Trustees on or before the second day of December, 1951, free of all expense, a copy of his dissertation with a motto thereon, and also accompanying it a sealed envelope bearing the same motto, inscribed on the outside, with his name and address within.

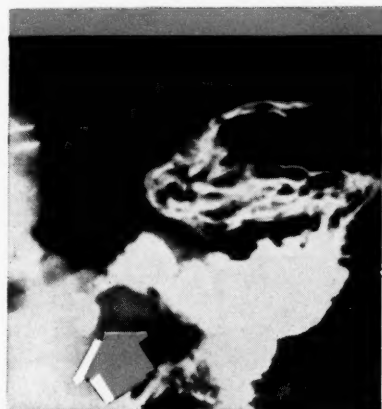
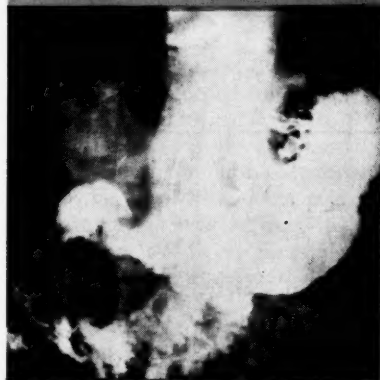
Previously to receiving the premium awarded, the author of the successful dissertation must transfer to the Trustees all his right, title and interest in and to the same, for the use, benefit, and behoof of the Fiske Fund. The successful author must agree to read his paper before the Rhode Island Medical Society at its annual meeting to be held in Providence on May 15, 1952.

Letters accompanying the unsuccessful dissertations will be destroyed unopened by the Trustees, and the dissertations may be procured by their respective authors if application be made therefor within three weeks.

The dissertations must be typewritten, double spaced on standard typewriter paper, and should not exceed 10,000 words. If the dissertation is illustrated, such illustrations will be published at the expense of the author.

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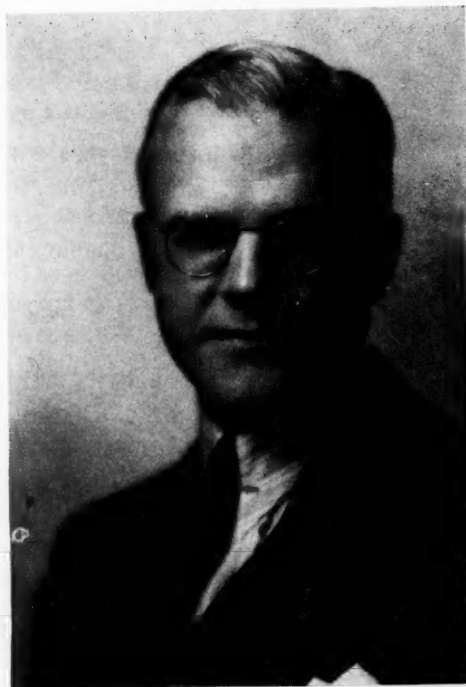
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PRESIDENT'S MESSAGE

TO THE FELLOWS of the Rhode Island Medical Society:

The year which has passed since our last Annual Meeting has brought new and serious problems to our country, problems which must take first place in our thoughts and plans. Upon us, as physicians, have been imposed responsibilities over and above those which most Americans must assume, because our Armed Forces must be provided with adequate medical care of the highest quality. Doctors are needed not only for those fighting in Korea but also for the expanding military force deemed necessary for national safety. We must meet our clear responsibility. We hope the burden will be apportioned in an equitable manner, and that those in authority will utilize the medical resources of the nation wisely.

In our daily contact with people in all walks of life we have an unusual opportunity to exercise that leadership for which our experience and education have equipped us. The present state of uncertainty in world affairs may be prolonged for years. Patience, foresight and extraordinarily good judgment will be necessary to preserve those assets which are of highest importance for the future. Ideas and ideals must be given as much weight as scientific and technical advances. Our educational system must be safeguarded so that there will be no future scarcity of educated men and women. We naturally have a particular interest in the preservation and extension of our American system of medical education, not only in medical schools, but in hospitals throughout the country, hospitals which are not necessarily affiliated with schools of medicine. We have reason to be proud of, and the public to be grateful for, the accomplishments of such education.

We must continue our efforts to solve the difficult problems involved in the distribution of medical care. Our voluntary health programs must be supported. They are probably not completely satisfactory either to patient or doctor. That is to be expected in new undertakings. Increasing experience will make it possible to improve them step by step, avoiding the inevitable errors of hasty and drastic changes made without the guidance of sound experience. In any event, organized medicine

is committed to the proposition that its voluntary programs can be developed not merely into a satisfactory substitute for compulsory health insurance, but rather into a better method of providing good medical care, particularly for those in low income groups. Under the circumstances the necessity for loyal support of our voluntary programs seems very obvious.

We shall undoubtedly continue to be subject to periodic attack and criticism from various sources. This should not disturb us too much. Most of such fault-finding can be and should be ignored. Much of it originates with those who are misinformed or unintelligent. Some have dubious motives; some are crackpots; some are "90 day wonders" who are wise because they have talked with wise men. We have good reason to be very proud of our profession and its accomplishments. We must not be complacent, but we can survive such petty though unfavorable judgments. What should seriously concern us, however, is that no reasonable censure should ever be justified. The solution is simple but not easy. We should never tolerate for any reason those things which we know are not right, for then we become very vulnerable indeed.

We should refute emphatically the false idea that the American Medical Association does not represent the doctors of America, or that it is dominated and controlled by any clique. My experience in the House of Delegates of the A. M. A. made it very clear to me that control of the A. M. A. is where it properly belongs, in the hands of the intelligent and conscientious doctors from every state in the Union, chosen by their State Societies and by elected representatives of every District Society in the land. That means you and me and every doctor in the United States who has joined, as he should, his local district medical association no matter how small it may be. It is not to be expected that we should all be in complete agreement at all times. Any of us should oppose vigorously in the democratic manner any policy or statement which seems unsound or otherwise objectionable, but we should give our wholehearted support to this organization of American doctors which has such a proud record of accomplishment.

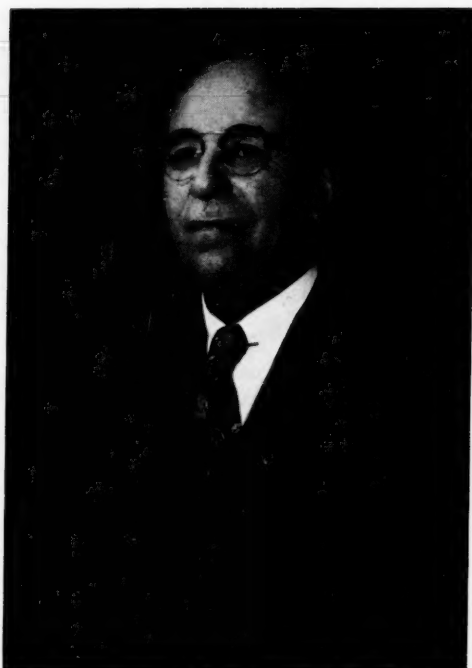
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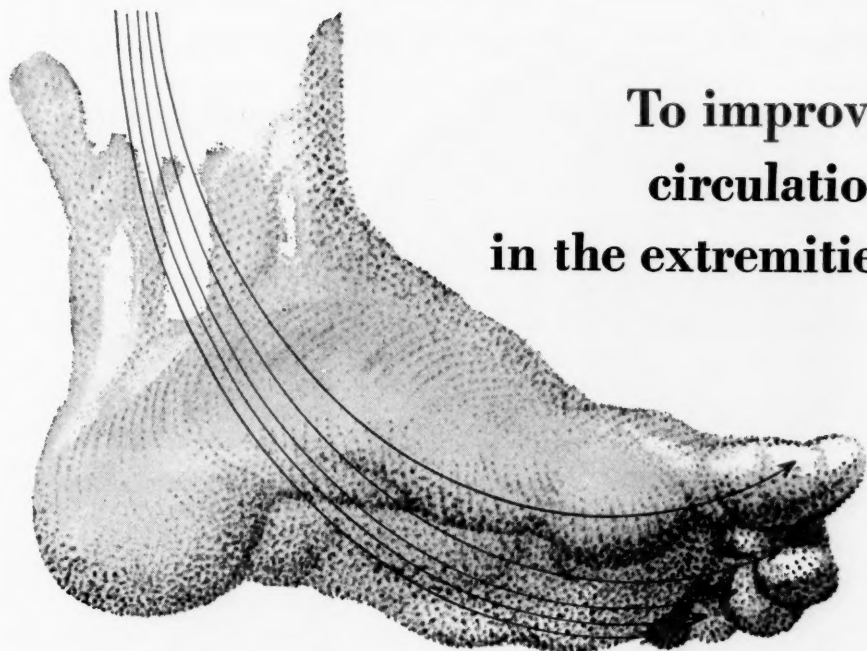
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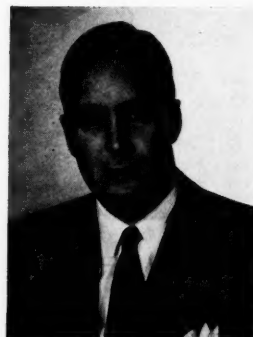
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*Crawley, G. A.: Clinical Study of Trocinate, A New Antispasmodic Drug. *M. Rec. & Ann.* 43:1104, 1949.



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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
— *Report of Meeting Held on April 18, 1951* —

A meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, April 18, 1951. The following were in attendance: *KENT COUNTY*: Peter C. Erinakes, M.D. *NEWPORT COUNTY*: Frank Logler, M.D. *PAWTUCKET DISTRICT*: James P. Healey, M.D., Henry J. Hanley, M.D., *PROVIDENCE MEDICAL ASSOCIATION*: Charles J. Ashworth, M.D., Frank B. Cutts, M.D., David Freedman, M.D., William Horan, M.D., Louis I. Kramer, M.D. John C. Myrick, M.D., Joseph C. O'Connell, M.D., Alfred L. Potter, M.D., Louis Sage, M.D., George Waterman, M.D. *WOONSOCKET COUNTY*: Saul Wittes, M.D. *OFFICERS*: Charles J. Ashworth, M.D., Earl F. Kelly, M.D., Herman A. Lawson, M.D. Also in attendance by invitation was Dr. Laurence A. Senseman.

In the absence of Dr. Morgan Cutts, Secretary of the Society, the reports were submitted by the Executive Secretary.

The report of the Secretary was presented as noted below. Several items in the report were discussed, particularly the question of the Committees on Chronic Illness, Group Insurance, and Blood Bank.

The report as submitted was accepted and placed on file.

REPORT OF THE SECRETARY

The Council of the Society has held two meetings since the last assembly of the House of Delegates. Among the matters resolved by the Council were the following:

The report of the Rhode Island State Commission on Alcoholism was referred to the Committee on Social Welfare with the request that it consider the report and make recommendations concerning it to the House of Delegates.

Approval was given the proposal that the Society share with the Providence Medical Association in the purchase of a motion picture projector that might be utilized by all the district societies for scientific meetings, as well as the State Society.

Received and reviewed the Treasurer's financial

report for the year 1950, and also received the auditors' statement.

The financial report for 1950, as submitted by the Treasurer, was carefully reviewed, and approved after the receipt of the auditors' statement.

The Secretary was authorized to inform all members of the Society who have retired from practice, or are inactive due to illness, relative to the procedure relative to AMA dues.

The report of the board of trustees relating to the installation of a dry well on the Library grounds to provide draining of roof water, and of a back-pressure valve on the sewer outlet to prevent overflow of sewerage into the building, was received and approved. The installation of these improvements has been carried out.

The President was authorized to appoint a Blood Bank Committee to cooperate with the Red Cross in the blood procurement program.

The Treasurer was authorized to pay from the Society's funds for the expenses incidental to the medical-dental lecture sponsored by the Society for physicians and dentists of the state.

The Council made known its views to the director of health services of Civil Defense for the State on several matters pertaining to medical phases of the program.

The President was authorized to appoint a Committee on Chronic Illness.

It voted:

To nominate Dr. Francis V. Corrigan as the official delegate of the Society to the 3rd National Conference on Physicians and Schools.

That the Society record its willingness to accept a donation for the use of the facilities of its building and facilities, as may be determined by the Treasurer of the Society and the Chairman of the Committee Advisory to the Selective Service system, should such facilities be requested.

To request the Committee on Medical Economics to investigate and report on plans for group insurance or security benefits for members of the Society.

Continued on page 272

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HOUSE OF DELEGATES

Continued from page 270

Recommendations from the Council

The following recommendation was presented from the Council:

The Council recommends to the House of Delegates that it authorize the Secretary to request, for the membership, to the Hospital Service Corporation and to the Rhode Island Medical Society Physicians Service, that members of the Society be permitted to be enrolled in either Blue Cross or Physicians Service, or both, under a comprehensive contract, the billing of premiums to be handled in cooperation with the executive office of the Society. It was moved:

To accept this recommendation and to instruct the Secretary to canvass the membership relative to the proposal.

The motion was seconded and adopted.

Nominees for officers and standing committees

The slate of officers and elected committeemen as drafted by the Council was submitted in ballot form to each member of the House.

There was a discussion of the slate by the members of the House, and counter nominations were offered to the Committee on Public Policy and Relations of Drs. Orland Smith and Jesse P. Eddy, and the Committee on Postgraduate Education of Dr. G. Raymond Fox.

On a written ballot the entire slate of officers and standing committees as submitted by the Council was elected, and the counter nominations were defeated.

The official slate of officers and standing committeemen is attached to and made part of the permanent records of this meeting.

Annual Report of the Treasurer

Dr. Earl F. Kelly, Treasurer of the Society, submitted his annual report for the fiscal year 1950. He also read a written report of the Society's elected auditors and stated that the Council had viewed and approved the report.

It was moved that:

The Treasurer's annual report be accepted, approved and placed on file.

The motion was seconded and adopted.

Commission on Alcoholism

Dr. Ashworth stated that Dr. Laurence A. Senseman, a fellow of the Society, and chairman of the Rhode Island Commission for the Study, Treatment and Care of Inebriates, had requested the privilege of addressing the House.

Dr. Senseman reported on the two-year study of the special commission appointed by the Rhode Island General Assembly which had made the study on alcoholism, and of which he was chairman.

He read the conclusions and recommendations of this commission which are as follows:

CONCLUSIONS: On the basis of the facts brought out by this study of the problem of alcoholism in Rhode Island, the Commission has reached two major conclusions:

1. The problem of alcoholism in Rhode Island is of such a magnitude that latest statistics available rank it 6th among the states in the rate of chronic alcoholism in the population. Rhode Island also leads all other states in the rate of increase of chronic alcoholism from 1930 with the rate more than doubling since then.
2. The methods and facilities now in existence in Rhode Island for dealing with the problem are very inadequate.

The importance of this study and the need for consideration of facilities for dealing with this ever-increasing problem in Rhode Island is thus apparent. It is the considered opinion of this Commission that the situation demands the serious attention of the General Assembly and action should be taken to improve this condition, based on the following principles:

1. The increased use of alcoholic beverages presents a problem affecting both the individual and society.
2. The alcoholic is not usually a bad person in need of a jail sentence but is a sick person.
3. The alcoholic is worth rehabilitating and in the majority of cases it is possible to do so.
4. Alcoholism is a complex problem and requires the combined efforts of doctor, social worker, clergy and others working in this area.

RECOMMENDATIONS: The Commission recommends the following program for treatment of the alcoholic in Rhode Island.

1. The establishment of a Division of Alcoholism with an advisory council within the State Department of Social Welfare, empowered to initiate and direct a program of rehabilitation for the alcoholic.
2. That people arrested as common drunkards be studied by the Division of Alcoholism before sentence is imposed on them by any court.
3. That the Division of Alcoholism provide for the care and physical welfare of all of the inmates of the various state institutions when, in its opinion, they need treatment for alcoholism.
4. The establishment of a centrally located facility as a state treatment center for the early diagnosis and treatment of alcoholics which would make available not less than 30 beds

Continued on page 276

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1. Gardner, L. I., Butler, A. M., et al.: *Pediatrics* 5:228, 1950.
2. Nesbit, H. T.: *Texas State J. M.* 38:551, 1943.
3. Dodd, K., and Rapoport, S.: *Am. J. Dis. Children* 78:537, 1949.
4. Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council.

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HOUSE OF DELEGATES

Continued from page 273

for in-patient care, as well as out-patient clinical facilities. Such an institution to be under the recommended Division of Alcoholism, should be equipped and staffed in such a way as to meet reasonable standards of hospital care and may utilize existing facilities or new construction, or acquire a building comparable in size to that of the Rhode Island Curative Center; patients to be admitted to such facility either voluntarily or involuntarily.

5. That the Governor and General Assembly provide funds to finance the development of a preventive, treatment and rehabilitative program for combating the problem of alcoholism.

In order to establish this program on a permanent basis, the Commission further recommends:

6. That the General Assembly enact the two suggested bills presented by this Commission and which the Commission feels will initiate a progressive program of rehabilitation to meet the needs of the alcoholic in Rhode Island.

* * *

Dr. Senseman sought the support of the House of Delegates of the Commission's proposals.

It was discussed by the House, and Dr. Senseman and Representative John J. Wrenn, present at the meeting at the invitation of Dr. Senseman, answered questions regarding the legislation introduced in the General Assembly to carry out the recommendations of the Commission. There was objection by the members of the House to the endorsement of the legislation with which the members were not familiar.

It was moved that:

The House of Delegates of the Rhode Island Medical Society approve in principle the report and recommendations of the Rhode Island Commission for the Study, Treatment and Care of Inebriates, but that it withhold at this time approval of any legislation for the General Assembly to carry out the recommendations.

Physicians Service

Dr. Joseph C. O'Connell, President of the Rhode Island Medical Society Physicians Service, read his report on the developments of that program.

It was moved that:

The report be accepted.

The motion was seconded and adopted.

The report is attached to and made an official record of this meeting.

Continued on page 277

Committee on Diabetes

At the request of Dr. Louis I. Kramer, chairman of the Committee on Diabetes, who had been called from the meeting, the Executive Secretary read the summary of the report relative to the Diabetes Detection Campaign conducted by the Committee in 1950.

It was moved:

To receive the report and place it on file.
The motion was seconded and adopted.

Benevolence Committee

Dr. David Freedman submitted copies of his report to the members of the House of Delegates relative to a proposal for a benevolence fund for members of the Society. The report was discussed.

It was moved to:

Accept the report and its recommendations.
The motion was seconded and adopted.

It was moved also that:

The present chairman of the Benevolence Committee be authorized by the House of Delegates to make changes and additions to the personnel of the Committee, reporting any actions he may take at the next meeting of the House. The motion was seconded and adopted.

Committee on Industrial Health

In the absence of Dr. Sprague the Executive Secretary presented the recommendation of the Industrial Health Committee regarding the appointment of members of this committee to include representation from various district societies.

It was moved to:

Refer this recommendation for possible action to the Council's Committee on Nominations for the slate of officers in 1952. The motion was seconded and adopted.

Committee on Public Relations

Dr. Charles L. Farrell, chairman of the Committee on Public Relations, reported on the various activities carried on during the war. He related regarding the showing of motion picture films sponsored by the Society, the survey of health facilities throughout the State, the development of the speakers' bureau, public education programs, and newspaper articles.

He also called attention to the problem relating to the release of persons from police custody for health reasons, and he asked for the authority for the Committee to continue its efforts to check on any such cases that appear questionable.

It was moved that:

The Public Relations Committee have the authority to act in the best interest of the Society on these problems as reported by the Chairman.

Continued on next page

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HOUSE OF DELEGATES*Concluded from preceding page***Committee on Social Welfare**

In the absence of Dr. Peter F. Harrington, chairman of the Committee on Social Welfare, the Executive Secretary read his report.

It was moved to:

Receive and place the report on file. The motion was seconded and adopted.

Fluoridation of Water Supply

The Executive Secretary read a proposed release from the State Director of Health to the presidents of the town councils, mayors of the cities, local health work officials, and water works management on the recommendations of the Department of Health relative to the fluoridation of public water supplies.

After a brief discussion, it was moved that:

The House of Delegates of the Rhode Island Medical Society endorse the fluoridation of public water supplies as a method of reducing the incidence of dental caries. The motion was seconded and adopted.

Miscellaneous Business

Dr. Charles J. Ashworth called to the attention of the House the information received this day that the case against the members of the Oregon State Medical Society relative to the operation by phy-

RHODE ISLAND MEDICAL JOURNAL

sicians of surgical-medical plans has been carried to the State Supreme Court.

* * *

Dr. Ashworth also noted that at the meeting of the Council of New England Medical Societies the sentiment had been expressed by several state society presidents that physicians must take a more active interest in the medical economics and sociological matters affecting the practice of medicine. He urged members of the House to stimulate members of the Society to work actively and to attend committee meetings and official bodies of the Society.

Dr. Ashworth, noting that this was the last meeting at which he would preside as chairman of the House of Delegates, expressed his appreciation to the members for the splendid cooperation they had given him during the past year.

The meeting adjourned at 11:20 p.m.

Respectfully submitted,

JOHN E. FARRELL, SC.D., *Executive Secretary*

ANESTHESIOLOGISTS ELECT

At a meeting of the Rhode Island Society of Anesthesiologists, held on April 9, the following were elected as officers for 1951: President, Elihu Saklad, M.D., Vice President, Thomas A. Egan, M.D., Secretary-Treasurer, Edward Damarjian, M.D.

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DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The annual meeting of the Pawtucket Medical Association was held at the Nurses' Auditorium, Memorial Hospital, on March 21, 1951. The meeting was called to order by the President, Dr. James P. Healey, at 12 noon.

The reading of the minutes of the previous meeting was omitted by the consent of the membership present. The annual report of the Secretary was read and accepted.

Dr. Henry E. Turner reported for the committee investigating emergency coverage and recommended:

1. That each member be responsible for his own patients, or arrange previously with a colleague for their care.
2. That the Pawtucket Medical Association recommend to the State Society that there be periodic publicity suggesting that the public make some liaison with a physician for their care.
3. That Welfare cases be investigated as to their facilities for emergency coverage.
4. That a volunteer emergency call list be made up.

Dr. Turner also discussed attendance at meetings and recommended:

1. That luncheon meetings be held with lunch at 11:45 a.m., business to start at noon and end at 1 p.m.

2. That the agenda for the coming meeting be sent to each member in the announcement for that meeting.

The President directed that the secretary send a list of these recommendations to members to be voted on at the next meeting.

Dr. William Kalcounos reported the findings of his committee's study of the recent request by the Blackstone Valley Medical Exchange for financial support. It was felt that their plan to charge the Association \$300 a month was not feasible. A motion to refuse the proposal was seconded and passed.

Officers to serve the Association in 1951 were elected. The slate is as follows:

President — Kieran W. Hennessey, M.D.
 Vice President — Laurence A. Senseman, M.D.
 Secretary — Hrad H. Zolmian, M.D.
 Treasurer — Harold A. Woodcome, M.D.
 Delegates — James P. Healey, M.D.
 Henry J. Hanley, M.D.
 Edward E. Trainor, M.D.
 Duncan H. D. Ferguson, M.D.

Councillor — Earl J. Mara, M.D.
 Alternate Councillor — Howard Umstead, M.D.

Dr. Hennessey, the new President, made a brief speech of acceptance.

The meeting adjourned until 7 p.m. when the annual dinner was held at the Sheraton-Biltmore Hotel, Providence. Dr. Laurence Senseman read the Treasurer's report at this time.

Guests included: Dr. Charles J. Ashworth, President of the Rhode Island Medical Society, Dr. Edward Morin, representative for the Pawtucket Dental Society; and Mr. Otto Bodemer, Superintendent of the Pawtucket Memorial Hospital.

Respectfully submitted,

HRAD H. ZOLMIAN, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

A meeting of the Kent County Medical Society was held on February 20, 1951. The meeting was called to order at 9 p.m. by the President, Dr. Jean M. Maynard. The minutes of the January meeting were accepted as read.

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Dr. Maynard stated this meeting was to be the financial meeting of the year and invited discussion from the floor.

Since other county societies have increased their accepted professional fees, and after considerable and due consideration, Dr. Hager made a motion that: The booklet entitled, "Rhode Island Uniform Fee Schedule for Governmental Agencies," be recommended as a guide for the setting of fees; That the Secretary send a copy of the paragraph entitled, "Visits and Examinations," on page 2 of this booklet, to all members of the Kent County Medical Society, to Public Aid Agencies, and to O.A.A. Departments of the County, dated as of March 1, 1951.

This motion was seconded by Dr. Young and unanimously accepted.

Dr. Young then reported for the Hospital Committee, stating that the By-Laws had been returned to him by the Board of Trustees, and that essentially all the changes recommended by the Kent County Medical Society at the January meeting had been allowed and incorporated. However, he stated that new articles and sections had been inserted. These additions had been made by the recommendation of legal members of the Board of Trustees. Article III, Section 8 and Article IV, Section 3 were notoriously unacceptable to the members of the Society.

Dr. Abbate made a motion that "The Kent County Medical Society go on record as advising the Board of Trustees that members of the Kent County Medical Society are not interested in becoming members of the Staff of the Kent County Memorial Hospital under conditions as outlined in Article III, Section 8 and Article IV, Section 3 of the By-Laws.

Dr. Hackman seconded this motion. It was put to a standing vote at the request of Dr. Wittig and passed unanimously.

The meeting adjourned at 11:30 p.m.

Respectfully submitted,

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MEDICINE IN THE NEWS

Dear Doctor Chase:

We are very much interested in your editorial "Quick and Poor Medical News" in the March issue of the RHODE ISLAND MEDICAL JOURNAL. For one thing we also had the experience of reading about Lowell's work in the newspaper while awaiting arrival of the journal containing the original article referred to. For another, we happen to have a collection of hundreds of letters from physicians which express their reactions to medical stories in the lay press. You may be interested.

Well, over a year ago, recognizing that such stories in the press, magazines and books, usually sensational but often incomplete, misleading, or lacking in substantiation, were becoming a matter of grave concern to the physician, we began to lay plans to help out in our own way. More and more popular magazines had discovered that public readership of medical stories was high, and of course it was inevitable that they would continue printing them. The only way to offset the effects seemed to be to let the physician know about what his patients were reading.

After careful and extensive study of the problem, and after testing of opinions of physicians in all parts of the country, we released, in August, 1950, a new monthly publication called "Medicine in the News — What Patients Read." It contained, as it still does, short summaries of medical stories reviewed in a wide assortment of popular periodicals. . . . Sources and authors were named, and, when used, trade names were reported in a completely impartial manner. "Medicine in the News" was designed for circulation only to practicing physicians. No advertising has ever appeared in it . . .

We feel that we have made considerable progress in forearming the physician against the effects of lay press medical story releases. The matter of prior release of such news stories by medical journals to newspapers, as described in your editorial, is a somewhat different problem. If the practice becomes more wide-spread it may be that they can be picked up in advance and reported to physicians by us in "Medicine in the News." And we shall be glad to do it. However, it seems more likely that objections from the profession itself will be the real answer to this problem, and editorials such as your own may well become the incentive to action.

With the thought in mind that you may not be familiar with "Medicine in the News," we are enclosing our most recent issue. . . . We shall also be more than glad to send it to any physicians on your staff who may not be already receiving it regularly.

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¹ I. Rose, W. C. (1949), Amino Acid Requirements of Man, Federation Proc. 8:546, June.

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Sir Heneage Ogilvie and William A. R. Thomson, editors—*Favourite Prescriptions*. The Practitioner, Lond., 1950. 4s. Moe Bergman—*The Audiology Clinic. A Manual for Planning a Clinic for the Rehabilitation of the Acoustically Handicapped*. Acta Oto-Laryngologica, Supplementum LXXXIX, 1950. Copies may be obtained by writing the Audiology Foundation, 1104 South Wabash Ave., Chicago, Illinois. \$1.00.

A PRIMER FOR DIABETIC PATIENTS by Russell M. Wilder, M.D. W. B. Saunders Company, Phil., 1950. 9th edition. \$2.25

Dr. Wilder has written this 9th edition with clarity and simplicity. In chapter after chapter, the basic physiology, insulin therapy, urine examinations, dietary planning, complications of diabetes and their management is written with such fundamental knowledge of the subject as to dispel fear from the mind of the diabetic.

This primer for diabetic patients is informative to the medical man and self-explanatory to the patient.

This book is a must because it puts Ease into a Dis-Ease.

LOUIS E. BURNS, M.D.

BRONCHIOESOPHAGOLOGY by Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S. and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S. W. B. Saunders Company, Phil., 1950. \$12.50

This book of 366 pages, divided into part one for Bronchology and part two for Esophagology, is very well arranged and written by the pioneer in this work and his son. It not only reviews the anatomy of the tracheo-bronchial tree, lungs and esophagus in detail but the diseases encountered and their treatment are admirably presented.

For the Oto-laryngologist there is no better reference book. The instruments used in this type of work are so well illustrated that any operating room Nursing Staff caring for peroral endoscopy should familiarize themselves with its contents. Herein we find an accumulation of knowledge collected

over a long period of time with all types of problems which present themselves in this field and a correct solution for them.

The last section, on diseases and abnormalities of the esophagus, is an addition which Surgeons and Medical Men should be interested in reading. Some parts certainly would prove helpful to the Pediatrician.

LINLEY C. HAPP, M.D.

CANCER AS I SEE IT by Henry W. Abelman. Philosophical Library, N. Y., 1951. \$2.75

The author of this book feels that cancer is an infectious disease caused by mold or fungus. There is little that is exact or convincing in the book.

PETER PINEO CHASE, M.D.

FUNCTIONAL ANATOMY OF THE LIMBS AND BACK: A Text for Students of Physical Therapy and Others Interested in the Locomotor Apparatus: by W. Henry Hollinshead, A.B.M.S., Ph. D., Head of Section on Anatomy, Mayo Clinic, and Professor of Anatomy, Mayo Foundation, University of Minnesota. W. B. Saunders Company, Phil., 1951. \$6.00

The secondary title gives the scope and purpose of the book. Although intended primarily for beginning non-medical students, the book contains certain features which render it invaluable to the advanced medical student or to the practicing physician or surgeon. After discussing the various tissues of the body in what he calls the organ systems, the author proceeds to discuss the movements of the various joints. By the use of line drawings with the muscles shaded, only the muscles involved in any one joint motion are depicted in any one figure. Taking the shoulder as an example, the flexors are shown in one figure; the extensors in another, and so on for the abductors, adductors, internal and external rotators. For the first time in this reviewer's experience, the different layers of back muscles are described in a comprehensible manner. The nerve and blood supply to the extremities are clearly shown. For good measure the head, thorax and abdomen are described in separate chapters. This book is invaluable for workers in rehabilitation clinics and should make a valuable addition to any reference library.

ROLAND HAMMOND, M.D.

Continued on page 288



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1. Walker, W.J.: Obesity as a Problem in Preventive Medicine, U.S. Armed Forces M.J. 1:393, 1950.
2. John, H.J.: Dietary Invalidism, Ann. Int. Med. 32:595, 1950.

BOOK REVIEWS

Continued from page 286

THE SCIENCE OF HEALTH by Florence Meredith, B.Sc., M.D. The Blakiston Company, Phil., 1951. 2nd ed. \$3.75

This book has been written as a text book for college hygiene courses. Its 452 pages, including the index and bibliography, encompass a wide range of material. Simple anatomy and physiology, a consideration of the national health situation, public health, mental health and personal health are among the subject matter discussed. The principles of these subjects are adequately presented and the student should gain a basic understanding of them.

There is a comprehensive section on mental health with good material on personality adjustment and normal human behavior. Under this section is an intelligent discussion of the emotional and sociological aspects of sex. The anatomy of the reproduction system and the physiology of sex are considered under a section entitled "The Next Generation", which, logically, also considers heredity and parental care. The subject of sex and other controversial subjects, such as alcohol and tobacco, are handled with restraint. Dr. Meredith avoids personal views and gives only generally opinions of medical science.

The material in this book is well organized and is clearly and concisely written. In addition to the basic scientific information it gives the student an understanding of the relationship of personal health to community health and offers valuable suggestions for personal healthful living, physically and mentally.

CLARA LOITMAN SMITH, M.D.

ENCYCLOPEDIA OF THE EYE, by Conrad Berens, M.D., F.A.C.S. and Edward Siegel, M.D. J. B. Lippincott Company, Philadelphia, 1950. \$5.00

Here is a small, handy, quick reference book which will be of value to the practitioner, his office employees, social workers, and others interested in the field of ophthalmology.

The material is classified in the style of an encyclopedia and is adequately indexed. There are several well chosen illustrations about half of which are in color. The topics are concisely treated, and in many instances supplemental information such as a classification of the disease or material useful in a differential diagnosis is given.

DONALD S. McCANN, M.D.

RHODE ISLAND MEDICAL JOURNAL

THE PHYSICIAN EXAMINES THE BIBLE by C. Raimer Smith, M.D. Philosophical Library, N. Y. 1950. \$4.25

This unusual and unique volume, is a remarkable compilation of Bible texts relating to every branch of medicine. Much study and thought have been necessary in the preparation of such an encyclopedia of texts and the large medical concordance for the Apocrypha.

One cannot read this book without gaining insight into the great significance of the Bible and its contribution to mankind throughout all the generations of the past and ever growing to meet the needs of the modern "atomic era." Chapter VIII

There is much in this book to stimulate the interest of the thoughtful reader of the Bible with its vast storehouse of knowledge, some of which have been only recently proven by science. It is apparent the author has a working knowledge of many of the sciences, allied to medicine, which makes the book of greater interest to a wider group of readers.

This book is written in a style easily understood by the layman and while repetitious in parts it emphasizes the positive value of the Bible.

While much controversial material is handled well one cannot wholly agree with all the generalizations that have been made.

This volume rightly emphasizes the authenticity of the Bible as Divinely inspired and for this it is commendable; but it failed to emphasize the value of prophecy both fulfilled and yet to be fulfilled.

This book would seem to have real value in assisting the busy doctor of medicine as well as the minister and student in the preparation of talks or sermons on medical subjects.

The summary and conclusions of Chapter IX are especially worthwhile and should inspire confidence in the greatest Book of all times.

LAURENCE A. SENSEMAN, M.D.

The Editor acknowledges the receipt of the following book:

Philip L. Harris and Wilma Kujawski — *ANNOTATED BIBLIOGRAPHY of VITAMIN E*, 1940 to 1950. National Vitamin Foundation, Inc., New York, 1950. \$3.00

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and weekends, at DEXter 1-5398**ARMY ORDERS RESERVES TO DUTY**

The Department of the Army announced today 250 medical officers of the Medical Service Reserve will be ordered into active military service during the month of May. The 250 officers are in Priority I as established by Public Law 779 of the 81st Congress.

This is the second group of medical officers ordered into active military service by the Army since December 26, 1950, when 890 medical and 850 dental officers were ordered to active service. During April, 300 medical and 100 dental officers were ordered to active service.

The officers will be given at least 30 days in which to close out personal and business affairs, unless they wish to report at an earlier date.

For the first time, the Department of the Army has called upon Army areas outside the continental limits of the United States to furnish medical officers in the present emergency. Puerto Rico will provide 13 and Hawaii, five.

Following is the number of medical officers to be ordered to active service from each Army Area.

ARMY	MEDICAL OFFICERS
First	33
Second	39
Third	29
Fourth	33
Fifth	49
Sixth	49
U. S. Army, Pacific	5
U. S. Army, Caribbean (Antilles)	13
TOTAL	250

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INTERIM MEETING**R. I. MEDICAL SOCIETY****WEDNESDAY . . . SEPTEMBER 19***Check the Date Now!***INDEX OF ADVERTISERS**

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The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: PETER PINEO CHASE, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

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Entered as second-class matter at the post office at Providence, Rhode Island

Single copies, 25 cents . . . Subscription, \$2.00 per year.

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June, 1951

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